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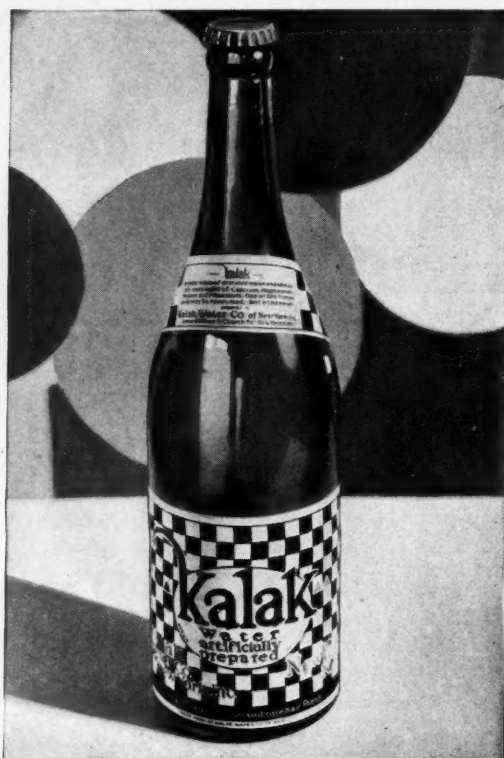
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ORIGINAL ARTICLES

AVERTIN ANESTHESIA IN GENERAL SURGERY*

By ANTHONY V. MIGLIACCIO, M.D.
282 BROADWAY, PROVIDENCE, R. I.

Tribromethyl alcohol, tribromethanol, or Avertin, as it is more commonly known, was first introduced to the medical profession by Duisberg and Willstaetter in 1923. Its acceptance, as an adjunct to our anesthetic armamentarium, has increased tremendously within the past few years and its popularity with the patient, anesthetist and surgeon is quite general. A popularity so universal could not be expected unless this new member possessed some desirable qualities not found in the other anesthetics.

Before delving into these qualities, may I digress for a moment to give some of the fundamentals about the drug, the method of administration, the indications and contraindications for its use.

The crystals of tribromethanol are dissolved in Amylene hydrate and the resulting liquid is marketed as Avertin.

The Avertin is administered to the patient as a 2½% solution. That is, each cubic centimeter of the Avertin is dissolved in forty (40) c.c. of water. It is of utmost importance to have the water at a temperature of not less than 95° F. and not more than 104° F. This precaution is necessary so as to avoid the breaking down of the Avertin, which occurs when the temperature is above 104° F., with the release of dibromacetaldehyde, a corrosive and irritant drug, which in the past accounted for the sluffing of rectum. With temperature below 95° F., complete solution of the Avertin in the water does not occur.

The required dose of the drug is dissolved in the correct amount of water, at the desired temperature, in a flask, by gentle shaking. The complete solution is attained when the heavy globules of Avertin fail to settle out of the water. At this stage

three drops of Congo-Red are placed either in the flask or in a test tube containing about five (5) c.c. of Avertin mixture. An orange color indicates the absence of decomposition products; a blue or violet shows the presence of these and means that the solution should not be used.

It is best to administer the anesthetic in the patient's room so as to avoid the emotional strain which is inevitably associated with the "ride" to the operating room. A cleansing enema should be given on the night previous to operation, if the operation is to be performed early, or, if it is to be performed later in the day, the enema should be given in the early morning. Morphine and atropine are used extensively pre-operatively.

With these preliminaries out of the way, the Avertin enema is given. It is best to use a 12 French soft rubber catheter on the end of a small funnel. The administration should take at least five (5) minutes.

Light, talking and all noises are best avoided, so as to obtain a smoother induction. Within five (5) minutes the patient's words are "thick and drawled out." Soon the eyes are closed and the patient falls into a light sleep from which he can easily be aroused, but, with time, this becomes increasingly difficult and within ten (10) minutes the patient is in a deep sleep.

The time of appearance of this stage of narcosis varies directly with the speed with which the Avertin enema is given. When the enema is given in less than three (3) minutes the patient falls into a deep sleep quite rapidly. This, however, should be avoided as it is apt to cause cyanosis and a greater drop in blood pressure than would ordinarily be encountered.

Patients practically never show any signs of excitement during the induction. To say that narcosis as induced with Avertin is the closest approach to natural sleep, so far available, may not sound impressive, but I feel certain that anyone who watches a patient "fall asleep" with this new anesthetic cannot fail but to be impressed with the truth of that assertion. TO SEE AN INDUCTION IS TO BECOME A CONVERT.

The patient's mental reactions are invariably pleasant and have been compared, by several, to

*Read before the Providence Medical Association, Dec. 5th, 1932.

the stage of euphoria, usually present in the earlier hours of alcoholic intoxication; others compare it to the deep sleep that one enjoys after an exhaustive day's work, while still others claim that a state of relaxation and freedom from worry so smoothly and so quickly overcomes them, that there is nothing else to do but to fall back and go to sleep. One high strung, nervous patient told me that it was the first time in years that she felt as though she were at peace with the whole wide world.

As the depth of narcosis increases, the patient's respirations become automatic. About ten (10) minutes after the enema, the respiratory excursions are deeper than normal, but by the time narcosis is obtained, the excursions are a little shallower than normal. With larger doses, however, the shallowness of the respiration is greater, but this can readily be overcome by the administration of carbon-dioxide. The pupil becomes contracted but reacts sluggishly to light.

A moderate blood pressure drop of from 10 to 30 points may occur but this is usually so insignificant that one rarely takes blood pressure readings through the operation.

The patient can now be taken to the operating room, care being taken to hold the jaw well forward so as to prevent occlusion of the larynx by the relaxed tongue and the concomitant cyanosis.

The dose of Avertin administered varies from 50 to 100 milligrams per kilogram of body weight and is dependent upon the age, sex, condition of the patient and the type of operation to be performed.

The maximum dose should never exceed ten (10) cubic centimeters in the male and eight (8) cubic centimeters in the female. However, after several trying experiences, I have limited by maximum dose to 7 and 6 cubic centimeters respectively and now find that satisfactory anesthesia can be obtained without resorting to the larger doses.

Avertin is used merely as a *basal anesthetic*, but large series show that in approximately thirty per cent (30%) of cases the operation can be completed without the aid of supplementary anesthesia. If, however, the anesthesia is deeper than desired, carbon-dioxide, strychnine, caffeine, ephedrine or adrenalin can be used to speed up elimination and lighten anesthesia.

In the extra-abdominal operations, where supplementary anesthesia is necessary, local infiltra-

tion of novocaine or administration of gas oxygen suffices. With the gas mixture we not only use a much smaller volume than ordinarily but also a greater percentage of oxygen.

In the abdominal operations somewhat more nitrous oxide is used and greater relaxation can be obtained if the anesthetist administers about one ounce of ether through the gas machine just previous to the opening, and, again, before the closing of the peritoneum. The patients rarely realize that a supplementary anesthetic was administered.

Avertin basal anesthesia can be used in practically every type of operation but it is especially advantageous in nervous individuals, in operations about the head and neck and in operations requiring considerable time. It offers special inducements to the gynecologists in combined vaginal and abdominal operations, for in these cases the vaginal work can be done with little or no supplementary anesthesia and it is not until the abdomen is prepared that gas oxygen need be given.

In operations about the mouth there is no face mask to obstruct and interfere with the surgeon. In operations for hyperthyroidism, Avertin is ideal, for in these cases the patient is asleep before he is even aware of the fact that he is being anesthetized, thus avoiding a great deal of unnecessary excitement and anxiety for the patient. Lahey has recently stated that Avertin can be used in post-operative thyroid crises.

The contra-indications can be summarized as follows:

1. Advance disease of the liver or kidneys.

This contra-indication is due to the fact that Avertin is probably broken down in the liver and is excreted by the kidney after it has combined with glycuronic acid. However, Shipley and Karns at the Johns Hopkins University Hospital examined the urine of eighty-seven (87) patients for twenty-four (24) hours after they had had Avertin and they found albumen and red blood cells in only four (4) cases. They looked especially for albumen, casts and red blood cells. They also used this anesthetic in ten (10) patients with prostatic disease, who had a diminished phenolsulphon-thalein excretion and some of whom had a high blood N.P.N. Others had hydronephrosis with infection before operation. Operations were performed in one and in two stages. Their post-operative studies showed no evi-

dence of new kidney damage and in no case was the blood N.P.N. increased.

Bourne and Raginsky, who studied the effect of Avertin upon the normal and impaired liver in dogs, concluded from their experiments that "Avertin can probably be used quite safely in individuals with moderate liver damage, though it is perhaps advisable to use a smaller dosage."

2. Obesity.
3. Ulcerative diseases of the rectum.
4. Extreme cachexia.
5. Dehydration.
6. Debilitated elderly patients.

The smoothness of the induction is paralleled by the ease and comparative freedom from discomfort experienced by the patient post-operatively, for the

patient awakens in his own room with complete amnesia of the incidents following the enema. A pleasant sleep of from two to twenty-four hours duration invariably follows the operation. During this period the tongue is completely relaxed and readily falls back, thus impairing respirations. To combat this, it is necessary to turn the patient's head to one side, to hold the jaw forward, to insert a nasal catheter or an airway.

Only about 25% of the patients are nauseated or vomit post-operatively. This, however, is extremely mild as compared to that seen after other general anesthetics. Gas pains are likewise mild and infrequent.

The shock so frequently seen after long ether operations is rarely encountered with Avertin. It is also remarkable to notice the pulse chart in these

TABLE No. 1

TYPE OF OPERATIONS	No. of Cases	Avertin only	Avertin and N ² O	Avertin and N ² O and Ether	Average Duration of Operation	Average Pulse	
						Start	End
A. HEAD AND NECK	20	14	3	3	37 min.	94	106
1. Ca. of Ear (Excision)		0	1	0			
2. Ca. of Tongue (Surgery or Radium)		5	0	0			
3. Bilateral Antra and Ethmoid and Septum		3	0	0			
4. Tonsils and Adenoids		1	0	0			
5. Repair of Cleft Palate		0	0	3			
6. Ca. of Mouth		2	0	0			
7. Thyroidectomy		1	2	0			
8. Glands of Neck		2	0	0			
B. THORAX	2	1	1	0	40 min.	92	101
1. Mastectomy (Local)		1	0	0			
2. Mastectomy (Radical)		0	1	0			
C. ABDOMINAL	36	0	12	24	60 min.	94	102
1. Exploratory Laparotomy		0	1	1			
2. Cholecystectomy		0	1	5			
3. Cholecystectomy and Appendectomy		0	1	8			
4. Appendectomy		0	2	7			
5. Colostomy		0	2	0			
6. Suprapubic Prostatectomy		0	1	0			
7. Inguinal Herniotomy (1 or 2)		0	3	1			
8. Ventral Hernia—Post-operative		0	0	2			
9. Pilonidal Sinus		0	1	0			
D. GYNECOLOGICAL	15	0	3	12	105 min.	90	102
1. Dilatation and Curettage		0	1	0			
2. Perineorrhaphy		0	2	0			
3. Laparotomy—Inoperable Ca.		0	0	2			
4. Salpingo-oophorectomy and App.		0	0	2			
5. Suspension of Uterus and Salpingo-oophorectomy and App.		0	0	2			
6. Suspension of Uterus and Salpingo-oophorectomy and App. and Amputation of Cervix		0	0	2			
7. Supravaginal Hysterectomy and Salpingo-oophorectomy		0	0	3			
8. Cesaerean		0	0	1			
E. EXTREMITIES	2	0	0	2	40 min.	100	120
1. Mid-thigh Amputation		0	0	1			
2. Traumatic Amputation of Arm and Fractured Jaw and Lacerations of Face		0	0	1			
TOTAL	75	15	19	41			

long operations. With Avertin the fast, thready pulse is a rarity and the patient usually leaves the operating room in a surprisingly good condition.

Post-operative complications attributable to Avertin are almost unknown. Frequently one hears mention of rectal irritation; this, however, is not seen today, but was not infrequently encountered when Avertin was first used. This improvement is due to the fact that we are no longer using the massive doses which were advocated at first and also to the fact that we guard against the irritant decomposition product of tribromethanol by keeping the temperature of the water, with which it is diluted, below the point at which this irritant, dibromacetaldehyde, is released and also by testing for its presence with Congo-Red. At the Johns Hopkins Hospital proctoscopic examinations were performed on thirty-six (36) patients, twenty-four (24) hours after the administration of Avertin, and in not a single case was the operator able to find any evidence of rectal irritation or ulceration.

It is with hesitancy and timidity that this small series of seventy-five (75) cases, in which I have had the good fortune to administer this new anesthetic, is submitted to you for consideration and evaluation. The report is presented only because it seems to represent a fair picture of the experiences gained by others from much larger series of cases.

The operations were performed at the Rhode Island, Homeopathic, Broadway and Charles V. Chapin Hospitals by nineteen different surgeons.

Table 1 presents a summary of the cases.

In this group 37% of the patients were males and 63% were females. Forty-one per cent (41%) were private and 59% were ward patients.

The maximum dose used was 100 mg/kg.

The minimum dose used was 50 mg/kg.

The average dose used was 85 mg/kg.

In 20% of the cases no supplementary anesthetic was used.

In 25% of the cases gas-oxygen was used as a supplementary anesthetic.

In 55% of the cases gas-oxygen and ether were used as a supplementary anesthetic. The amount of ether used varied from half an ounce to eight ounces. The average, however, was only 2½ ounces.

Anesthesia as obtained under these conditions was considered unsatisfactory in one case, partly unsatisfactory in two cases and satisfactory in the remaining seventy-two (72) cases.

In five (5) patients, Avertin was chosen over ether because of the presence of pulmonary complications. Two of these patients had acute bronchitis, two were severe asthmatics and one had a healed pulmonary tuberculosis. In these five patients the operations were completed without the use of ether, thus avoiding further pulmonary irritation.

The ages of the patients in this group varied from one and three-quarters years ($1\frac{3}{4}$) to eighty-one years (81), with the majority falling into what is commonly referred to as the middle age, as shown by the accompanying table.

TABLE No. 2
AGE INCIDENCE IN GROUPS
Number of Cases—75

Decade	% of Cases
1-9	3%
10-19	5%
20-29	10%
30-39	26%
40-49	25%
50-59	13%
60-69	6%
70-79	10%
80-89	2%

The average duration of operation as shown in Table No. 1 was 60.2 minutes. The shortest operation required fifteen (15) minutes, while the longest required two (2) hours and fifty-two (52) minutes for completion.

The post-operative complications attributable to the anesthetic can best be summarized as follows:

1. Death: None.
2. Rectal Irritation: None.
3. Pulmonary: None.
4. Nausea and Vomiting: This occurred in only 27% of the cases and except for the two cases noted below, was extremely mild.

The first case of profuse vomiting was encountered in a patient who had had insertion of radium for an extensive Ca. of body of fundus of uterus, which was found at laparotomy. In this case the vomiting started twenty-four (24) hours after the completion of the operation and was, in all probabilities, due to the radium.

The second case occurred in a patient who had had a difficult cholecystectomy performed. This patient had been submitted to two previous operations and at the time of the cholecystectomy, extensive, dense adhesions were encountered.

5. Cyanosis:

Marked cyanosis was present in two cases. In the first one, relief was obtained by the insertion of a nasal catheter, while in the second case establishment of drainage, in a markedly edematous neck, that had been operated upon, brought relief.

6. Stoppage of breathing:

This occurred twice in this series, once during operation and once about twenty (20) minutes after the completion of the operation. In both of these cases ordinary methods of resuscitation were employed successfully. Neither one of these patients was deeper than in a second stage anesthesia at the time that the "breath-holding" episode occurred.

The post-operative complications other than those due to the anesthetic are as follows:

1. There were two deaths. The first occurred five days post-operatively in a patient who had had a second stage prostatectomy. Death in this case was due to uncontrollable hemorrhage and old age. The second death occurred several hours post-operatively, in a patient who had had a traumatic amputation of the arm at the shoulder, extensive laceration of the face and neck and multiple fractures of the mandible. Death here was due to hemorrhage and surgical shock.
2. One patient developed a pyelitis due to a kinked ureter following an operation in which a supra-vaginal hysterectomy and Rt salpingo-oophorectomy had been performed.

In conclusion it seems fair to state that Avertin when used to produce basal anesthesia is not only safe and efficient, but also succeeds in taking the unpleasant experiences and memories away from the operation.

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THE UNDERSTANDING AND TREATMENT OF THE NERVOUS CHILD*

By DR. HAROLD F. CORSON

163 BOWEN ST., PROVIDENCE, R. I.

The Child Guidance Clinic studies the nervous child particularly from the angle of personality, behavior and educational developments. The clinic set-up consists of a social worker who gets the history with special reference to behavior and personality trends; the psychologist, utilizing various standardized tests, measures the abilities and disabilities of the individual; and the physician who considers the health problem and mental aspects together with the information already obtained.

It is scarcely necessary to state that in medicine we are no longer satisfied with the treatment of symptoms without some attempt to ascertain etiological factors. In our approach we assume that personality and behavior manifestations are to a large extent symptomatic of the child's attempt to meet his particular situation. For example, if we consider such a simple thing as a temper outburst it would be possible to give numerous causes. To prescribe punishment without investigation is not unlike giving morphine for a stomachache without any attempt at inquiry.

The first step, then, must be a diagnostic study not only of the individual but also a consideration of the persons and situations with whom the child comes in contact. In principle certain steps are

*Read before the Rhode Island Medical Society, June 2, 1932.

necessary. In practice it may be possible to consider causative or etiological factors in a very brief period. They may be grouped under the following captions:

- (a) Hereditary and constitutional endowment.
- (b) Physical development and health problems.
- (c) Special abilities and disabilities.
- (d) Social development (i) within the family; (ii) in the community; (iii) economic status of home; (iv) training or lack of training.

In the large majority a satisfactory balance between conflicting forces is achieved and we have the average or happy child. In a smaller group due either to constitutional variations or to some more difficult situation the unhappy or nervous child develops. It is evident that different individuals may either react to similar situations in a diverse manner or that like reactions may arise from diverse situations. In this paper it is proposed to emphasize the more common types of reactions of the nervous child and to consider only in a cursory fashion the variety of etiological factors. In dealing with the child it is to be remembered that very frequently relatively simple measures may achieve results that would be much less probable in the adult where personality and behavior habits are more firmly entrenched. It is also to be remembered that certain activities are more or less age determined and that with proper treatment can be expected to drop out with the passage of time. Frequently the physician can be of real assistance to the parent in interpreting and evaluating the cause of concern. There are, however, a number of reactions that must be considered as important and worthy of attention. These can be listed as follows:

(a) *Persistence of Infantile Behavior.*

Ordinarily the infant can be expected to grow from complete dependence on the parents to a more or less independent adult. The parent may not recognize the significance of the behavior and very frequently is blind to his or her own need in having a very dependent creature to care for. A six-year-old girl was brought to the clinic because of crying spells, stubbornness, and the necessity of special attention in dressing and feeding. In the clinic the girl crawled up in her mother's lap, cried and acted very much as a younger child might. The mother herself was very insecure and felt that the husband was very critical of her. The financial situation together with an unsatisfactory neighborhood in-

creased this insecurity, isolated the child from other children and tended to retard the child's progress toward a more independent existence. In short, the mother found her greatest need supplied by a dependent creature while the child maintained her position in the home by insisting on certain types of attention. Treatment here consisted largely in modifying the mother's attitude and secondarily in working directly with the child.

(b) *Return to Infantile Behavior after a More Mature Stage Has Been Reached—Regression.*

A nine-year-old girl was brought to the clinic because of baby talk, strange gait, poor adjustment in school, petulance, stealing, etc. In studying the child it was found that she had normal intelligence and no matter how careful the physical or neurological examination no organic basis could be found for it. As a result of the study it was felt that this girl was attempting to compete with a younger sister and an asthmatic brother, simulating the behavior of a younger child. One could not say that this was entirely deliberate. Certainly in treatment a great deal was done not so much through the child but through the parents. Treatment was based on the principle that much of the patient's behavior was an attempt to compete with the favored siblings and with the removal of the necessity for this competition there resulted a rapid clearing of the undesirable behavior.

It might well be added that comparisons while often a source of stimulation are as frequently the basis of feelings of inadequacy and undesirable traits.

(c) *Paranoid Reaction.*

Another type of reaction that is seen not so frequently in a child is what might be described as paranoid. Here the child tends to place the responsibility for his shortcomings on the shoulders of someone else. For example, a boy was referred because he was the cause of constant trouble in the school. The psychologist's examination showed that the boy was trying to do work that was entirely beyond him. The boy's attitude in spite of these tests was that the teachers were spiteful against him and were deliberately giving him low marks because they did not like him. He in turn tried to make things difficult for them by misbehaving. The treatment plan in this case consisted partly in working with the school and giving them our view-

point of the case. The boy was given work that was in keeping with his ability and at the same time we worked with him at the clinic in pointing out just how he had faced his particular situation. The result was that during the course of the following year he made a satisfactory adjustment in school. The boy, the school and the clinic all contributed their part toward the solution of this rather difficult situation.

(d) *Hysterical Reactions.*

Under this heading a number of superficially very different cases might be given as illustrations.

A girl of eight was referred to the clinic after a careful study by an ophthalmologist. His findings indicated that the attacks of fluctuating blindness and inability to read were not due to any organic lesion. In this case the clinic felt that although there was sufficient material in the girl's mental life to explain the phenomena we were extremely anxious to avoid the possibility of some obscure physical or neurological condition. This was ruled out and the study of the child and home situation showed a number of causative factors. One factor could be considered as undue insistence on lessons at home, the second factor was wakefulness at night on a fear basis, third was conflict over her origin, and fourth, the constitutional factors that are difficult to evaluate.

(e) *Hypochondriacal Reactions.*

In handling this type of case the most accurate and careful type of medical diagnostic study is necessary. Certainly if anyone is to treat this condition either in a child, adolescent or adult, the starting point of his treatment has to be a demonstration of the fact that no physical disease exists or the degree of the illness. In one of the cases we saw at the clinic the complaint of heart disease had resulted in medical examination and no organic lesion was demonstrable. From the school came the complaint that the girl was failing in her work. Attempts to assure this nine-year-old girl that there was no heart lesion and that she was all right had not been effective because of continued discomfort, palpitation, etc. When the study of the home situation and the child was completed it was evident that this girl's home situation was not satisfactory. Although she was the oldest child she was not capable of assuming the responsibility that the parents had unwittingly placed upon her shoulders. She was

worrying about family finance and family problems with which she should at best have had a limited acquaintance. The mother without thinking was inclined to blame her and hold her responsible for any mishap that might occur to the younger children. The psychological tests had indicated that the girl's intelligence was average and that she should ordinarily have no trouble in school. Although the treatment extended over some little time the results were almost at once evident. Treatment here was in the sense of modifying attitudes not only of the parents but also of the child. The evidence of success in treatment is indicated in the dropping out of heart complaints, success in school and a more happy attitude toward the home.

One of the very common factors that cause difficulty is the discussion of the child's symptoms and condition before him whether by the parents or by parents and physician.

(f) *Fear and Worry Reaction.*

A boy was referred to the clinic because of "seizures" which the physician felt were psychic in origin rather than true epilepsy. The fear and worry tendencies of the patient were outstanding components. Treatment in the clinic has been marked by its ups and downs. The mother would occasionally become discouraged with our approach and would go to a physician who would make the diagnosis of epilepsy. The clinic constantly insisted, as did the physician who had originally seen the case, that the seizures were psychic in their origin. This case was also put to the test of a period of observation in a hospital. Here, separated from the mother, no attacks occurred. It seems probable that after about two years of observation and study partly under controlled conditions that we can insist with justification that this is not epilepsy we are dealing with and it seems very probable that we have convinced the mother that the attacks are brought on by some overstimulating situation. For example, an attack might follow within twenty-four hours after an exciting event. Usually an analysis of the period preceding the attack would demonstrate some gross error in management of the child and a marked fear reaction. This, in spite of the fact that the parents were to all intents and purposes rather intelligent.

(g) *Rebellion.*

In this group we find that the individual instead of accepting his limitations and attempting an ade-

quate compensation tries to force his way by unsatisfactory procedures. This behavior may be of various kinds and evidences itself in the home, the school and on the playground. We are most familiar with it in the adolescent who refuses to behave in accordance with social demands. Authority in any form stimulates adverse behavior. Treatment must be based on an understanding of the basic factors.

John, age ten, came to the clinic because his father claimed he was incorrigible. His mother was dead and his grandmother, together with the father, a couple of uncles and an aunt, were all working hard to keep this boy in line. It is evident that here was too much authority which was often inconsistent. The rebellion was actually more to be desired than acquiescence. The family group had to decide on some delegation of authority, the boy on his part had to accept responsibilities within his limitations and certainly he was entitled to some privacy and freedom of action.

(h) *Withdrawal from Reality.*

In contrast to the group that rebels this group tends to withdraw from the difficult situation. A very common device is the tendency to daydream and to live in a world of fantasy. Truancy from school or home or avoidance of playmates may be noticed. In the schoolroom the child may find the work too difficult or, handicapped by a visual or hearing defect, is unable to understand what is going on—one way out is to withdraw into a more pleasing world of fantasy. On the playground physical handicaps or inability to play certain games may result in unsatisfactory relationships and the individual resorts to a companionship with younger children or to solitary occupations.

A boy was referred because he was failing in his school work, was inattentive, listless and at times stubborn. The history revealed that his school progress had been average up to one year ago, when he had had a severe illness with apparently complete recovery. The most outstanding finding was a hearing defect that had not been recognized by the teacher and had not been considered important by the mother. Actually the deafness was of sufficient severity to seriously handicap the boy in the schoolroom. Inattentiveness and stubbornness were very definitely due to failure to grasp what was desired by the teacher.

It might be well to add that frequently com-

plaints are made about inability to see or to hear, when actually the real problem may be due to inability to comprehend or inattentiveness due to daydreaming or concern about some other topic.

(i) *Apathy or Overactivity.*

In cases of apathy or overactivity the question often arises as to whether it is on a physical or mental basis. Attempts to build up the physical health without consideration of other factors are often disappointing.

One must take into account particularly the daily routine, and insistence on a satisfactory program is often the basis for good results. Too often mothers are having difficulty because they are attempting to fit the child into some rigid routine which is recommended by various pamphlets prepared for their consumption without recognition of individual differences, while on the other hand they may be following a *laissez-faire* program which may be equally disastrous. Very frequently the child is to be handled by giving him satisfactory activities and satisfactory playmates. At this time it is not possible and it is not necessary to go into details of proper routine, particularly for the younger child, but many problems are more or less automatically solved when the whole twenty-four-hour program is considered in detail. For example, a mother may complain about inability to get her child up in the morning while forgetting that he does not get to bed at a satisfactory time, possibly a particular radio hour seems to necessitate a late hour. Occasionally routine has been arranged because of adult needs which are not at all in keeping with the needs of the child.

Conclusion.

It has not been possible to take up every type of case with which the clinic attempts to deal nor is it possible to give in detail our handling of one case. We are attempting to meet certain types of human problems that in many cases lie in the mental field while others lie in that very difficult territory between what is physical and what is mental. Our general viewpoint consists of viewing the individual as a whole and even though he may be suffering from a very typical type of disease yet we insist that his particular reaction is the result not only of the disease process but also of his hereditary and experiential background plus the situation in which he must carry on.

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EDITORIALS

OUR "SHOPLIFTING" PROBLEM

Among other conclusions in the Report of the Committee on the Costs of Medical Care is the following paragraph:

"Losses from bad accounts are not peculiar to physicians, but in no other legitimate field of endeavor are the losses so high as in the practice of medicine, nor is there such an attitude of propriety on the part of the public in failing to pay bills."

What a commentary—and all too true a one—on the American propensity of "putting it over." Put in less kind terms, the public by systematized cheap and petty thievery is shoplifting from its physicians their hard earned and dearly bought stock in trade, knowledge.

That knowledge was gained from years of most rigorous training and education—the prime years of youth—often at the added cost of parental self-sacrifice and in many cases true privation suffered by the medical student himself in his effort to learn well his profession.

And when he starts out in practice with unbounded enthusiasm of medical science, true altruism towards all suffering mankind, and a desire to serve faithfully and well his patients, intentionally giving much of his time and knowledge and personal strength for charity, this same young physician is soon disillusioned by deliberate filching on the part of trusted clients.

It is next to impossible to improve the moral conscience of the public at large, but it does behoove every physician in practice to insist on the collection of his just rewards where he knows of the ability to pay them. This is a moral obligation towards his colleagues so that the negligent patient will not prey further upon the altruism of the profession.

No one can deny our full fine willingness to strain our efforts to the utmost with no better reward than satisfaction when the bona fide charity patient is involved, but the deliberate cheating dead-beat and the organized attempts to steal our hard earned and just rewards should be met with a counterattack to force collection rather than an attitude of complacent and injured acquiescence.

If we will get together and collect our bills, "our public" will give us more respect and appreciate our services.

REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION

DR. REUBEN C. BATES

Certified milk in Providence was obtained from the following farms during the year 1932:

Alta Crest Farm, Spencer, Mass.

Cherry Hill Farm, North Beverly, Mass.

Cocumcussoc Farm, Wickford, R. I.

Fairoaks Farm, Lincoln, R. I.

Walker-Gordon Farm, Charles River, Mass.

Through the co-operation of the Boston Commission we have accepted their certification of three farms in Massachusetts.

Fairoaks Farm of Lincoln, R. I., has been placed under our supervision and their milk is certified by your Commission. During the past year a member of the Commission has visited both local farms each month and their spirit of co-operation has been very gratifying.

Bacteriological and chemical examinations of the milk are made twice weekly in the laboratories of Brown University and during the year over 400 examinations have been performed and 98% tested below the 10,000 bacteria per C.C.

The personnel of the Commission includes Drs. William P. Buffum, Maurice Adelman, William H. Jordon, A. R. Newsam and Reuben C. Bates, Secretary.

ALTA CREST				HOOD'S (Cherry Hill)			
	B.F.	T. Solids	Average Bacteria Count Per C.C.		B.F.	T. Solids	Average Bacteria Count Per C.C.
Jan.	4.14	12.93	3520	4.82	14.16	6500	
Feb.	4.23	13.91	2600	4.90	14.17	4850	
Mar.	4.27	13.26	1590	4.85	14.07	3640	
Apr.	4.24	13.23	4776	4.81	14.11	3775	
May	4.08	12.79	2338	4.75	13.97	2888	
June	4.10	12.66	2013	4.63	13.48	6575	
July	4.07	12.55	4863	4.49	13.47	2263	
Aug.	3.93	12.47	2638	4.38	13.49	1938	
Sept.	3.52	12.46	9940	4.12	13.57	1250	
Oct.	3.78	12.70	3663	4.78	14.17	1900	
Nov.				4.70	14.17	1350	
Dec.				4.43	14.44	2541	
Total Ave. for year	4.03	12.90	3794	4.64	13.94	3289	

WALKER-GORDON				COCUMCUSSOC			
	B.F.	T. Solids	Average Bacteria Count Per C.C.		B.F.	T. Solids	Average Bacteria Count Per C.C.
Jan.	4.23	13.18	6970	3.89	13.42	20616	
Feb.	4.35	13.33	5175	4.25	13.24	13525	
Mar.	4.24	13.18	4600	4.43	13.51	4450	
Apr.	4.08	12.98	5500	4.30	13.38	6337	
May	4.14	12.85	3250	4.14	13.01	10516	
June	4.19	12.80	3838	4.43	13.20	9692	
July	4.08	12.65	3413	4.39	13.22	10461	
Aug.	4.16	12.73	3238	4.39	13.32	5462	
Sept.	4.12	12.76	1910	4.30	14.07	3247	
Oct.	4.15	13.15	1225	4.68	13.97	2025	
Nov.	4.20	13.11	1835	4.75	13.90	1967	
Dec.	4.15	13.13	2083	4.86	14.15	1954	
Total Ave. for year	4.17	12.99	3578	4.40	13.53	7521	

FAIROAKS			
	B.F.	T. Solids	Average Bacteria Count Per C.C.
Mar.	4.80	13.90	3690
Apr.	4.58	13.85	3655
May	4.38	13.35	4597
June	4.46	12.44	19040
July	3.52	12.41	6792
Aug.	4.59	13.28	7760
Sept.	4.85	13.90	3430
Oct.	4.60	13.66	4119
Nov.	4.68	13.89	2400
Dec.	4.91	13.80	3320
Total Ave. for year	4.54	13.44	5880

CLINICAL-PATHOLOGIC CONFERENCE

RHODE ISLAND HOSPITAL

Case reported by Dr. Charles Gormley.

The following mimeographed history was passed out:

C. P., a married white woman, age 24 was admitted to the R. I. H. in an unconscious condition at 12:45 P. M.

Present Illness: The following history was obtained from the family physician and parents: Ten days before admission the patient had an attack of fever with chills, general aches and pains and malaise described as influenzal. This attack continued for 3 days and then abated, and the patient felt fairly well for the following 2 days, when she had a severe chill with high fever which continued for 3 days. At this time the left lung was found to be dull and no breath sounds were heard. No cough was present. The temperature again dropped, only to recur the next day with a succession of chills. The patient complained of pain in the lower part of her chest (epigastrium) but there was no cough. On the morning of admission she had generalized convulsions, during which it was noted that her back was arched. She had been conscious up to 2 days before admission, when she failed to recognize anyone and had been unconscious since.

Past History: Had always been in generally good health. No detailed history was obtained.

Family History: Non-illuminative.

Physical Examination

Disclosed a well developed young white woman lying quietly in bed, not responding to questions nor stimuli and breathing rapidly and shallowly.

Head: Scalp, ears and nose negative. Pupils equal but reacted to light sluggishly. The eye-lids had moderate tone. The tongue was coated. It was noted that there was dilatation of the alae nasae with inspiration.

Neck: Small, palpably firm anterior cervical glands were present. There was a scar in the left side of the neck, apparently from previously removed glands.

Chest: There were shallow and rapid respiratory excursions, less marked on the left side.

Lungs: The right side was apparently normal. The left side was dull to percussion, especially over the lower lobe, and the breath sounds were distant.

The respiratory grunt came through the left lower lobe with a nasal quality. Fremitus, voice sounds and whispered pectoriloquy could not be ascertained.

Heart: The pulse was 98 and the rhythm regular. The blood pressure was 92/40. There was slight increase of the area of dullness to the right of the sternum. The cardiac sounds were masked by the respiratory sounds.

The abdomen and extremities were negative.

Reflexes: The superficial abdominal reflexes were absent. The conjunctival reflexes were weak. The knee and ankle jerks were absent. The biceps and triceps jerks could not be elicited. No ankle clonus nor opisthotonus was noted. There were questionable Babinski and Kernig signs and only slight rigidity of the neck which was, however, not present on subsequent examination. The neck and contralateral Brudzinski signs were absent.

Skin: There was only very slight cyanosis but fairly well marked pallor.

Laboratory Findings: The white blood count was 29,300 with 87% polymorphonuclears. The initial pressure on lumbar puncture was 150 mm. with normal dynamics. The pressure after removal of 35 cc. of rather clear fluid was 60 mm. Two colonies of staphylococcus aureus were cultured from the spinal fluid. Two blood cultures revealed staphylococcus aureus. Inasmuch as the patient was incontinent, no urine was obtained for study. In view of the extreme condition of the patient and the brief duration of the illness in the hospital, no X-ray was obtained.

Progress Notes: The patient rapidly developed cyanosis and was kept in the oxygen tent almost continuously. The temperature, which was 105° on admission, varied between 104° and 105.8°. The respirations rose from 32 to 44 per minute. The patient continued to be incontinent of urine and stools. The pulse suddenly began to fibrillate, but promptly resumed a normal rhythm following the intravenous injection of ¼ mg. of strophanthus. The fundi were examined by Dr. Messinger. He found the right disc blurred, completely elevated and containing large peripapillary hemorrhages. The left disc was blurred and contained a few small peripapillary hemorrhages. The papillary reactions were less marked on the left side.

The patient failed to respond to stimulation, became cyanotic and expired, 25 hours after admission. At no time had she regained consciousness.

Discussion

DR. GORMLEY: "This case which is being presented from the second medical service is a young woman twenty-four years old who was brought in unconscious and who died something over twenty-four hours after. She was sent in with a diagnosis of pneumonia and was totally unconscious. No history was obtained until the afternoon of the day she was admitted. An effort was made to obtain a history from her physician, but he was out of town. Physical findings at that time seemed to confirm the suggestion that she had pneumonia and very little was done in the way of treatment. Later in the afternoon when we saw her parents, we found that she had what was called influenza which later developed into pneumonia. This history was—'Ten days before admission the patient had an attack of fever with chills, general aches and pains and malaise described as influenzal. This attack continued for three days and then abated and the patient felt fairly well for the following two days when she had a severe chill with high fever which continued for three days,' etc.

"This girl did not respond very well to the oxygen tent. She died a little over twenty-four hours after admission without regaining consciousness. One of the things we needed most in this girl was an X-ray examination, but her condition was critical, so we did not take one and I did not know until just now that there was one taken. It must have been taken on the way to the ward.

"Our problem with this girl was to explain what her unconsciousness was due to. She was seen on the truck before she was put to bed, and she was seen in the middle of the afternoon, and a third time just before she died. Our best guess as to the cause was that she was developing a staph. meningitis. We had the blood culture report on the morning of the day she died—also, we knew about her positive spinal fluid."

Q.: "Was she given any antipneumococcic serum?"

A.: "Yes, it was given to her on admission but we had not proved the type of her pneumonia.

"It seems to me that the question in this case is the relation between her sudden acute respiratory illness (if the history is correct) and her unconsciousness. I have asked Drs. DeWolf and Burgess if they will say something."

DR. DEWOLF: "The question of this case seems to me one of an overwhelming septicemia. The

woman lived for eleven days according to this history, and going over it you notice at the beginning she was sick for three days and then she was better for a few days and then again very ill. Some of this brings back the story of the old 'Flu' cases. First she was suffering for three or four days and then seemed to get better, and then pneumonia came along and the patient died. There was no question, of course, that the lungs were involved, and really, from the academic point of view, it comes to my mind as to whether there may have been fluid in that chest as well as pneumonia. The heart was pushed over to the right, and you note somewhere here that the breath sounds were shallow and it looks as if there might have been some fluid as well as pneumonia. I think one is struck by the fact that the knee and ankle jerks were absent. The Babinski and Kernig were not marked and the spinal pressure was normal. Apparently it looks as if there might have been a shut off somewhere in the brain. There is no note here on any abdominal findings, but with this type of infection I think possibly there might have been something in the abdominal organs."

DR. GORMLEY: "It says on the last line of the first page that the abdominal organs and extremities were negative."

DR. DEWOLF: "She had a blood stream infection, and it seems as though she must have had a meningitis, with all the findings, and that would account for her convulsions and her unconsciousness. The point that came to my mind is that she had small cervical glands with an old scar. This thing does not look tuberculous in any way, and yet it comes to mind as you read it over and a T.B. infection can be very virulent. I am making a guess before we look at the X-rays that it was pneumonia."

DR. BURGESS: "My impression was like Dr. DeWolf's. She was overwhelmed by that infection. It brings up an interesting study in 1918. There was a large series of influenza reported in one of the Southern camps. That seemed to account for quite a number of those influenzas in 1918. Since that time we saw the same thing in this hospital. During that outbreak we had one or two of this type. In 1929 we had two cases of pulmonary deaths from influenza. In one we found staphylococcus aureus in the blood stream. I feel that the staphylococcus is certainly about the worst infection to invade the blood stream. I want to ask

whether there are any skin indications in these cases at all. I think she was overwhelmed by the staph. infection. There is probably a massive pneumonia with areas of softening as you often get."

DR. GORMLEY: "I would like to bring to Dr. Burgess' attention the white blood count of 29,300."

DR. BURGESS: "Yes—I meant to add that. In those cases that Dr. Gormley spoke about that we reported a few years ago and the so called agranulocytosis there was a leucopenia."

Demonstration of X-ray Film

DR. BATCHELDER: "The film brings out several points of confirmation of the physical findings. An area of dullness in the lower two-thirds of the chest. At the time it was reported pneumonic consolidation, but a note was also added that the possibility of the presence of a little fluid should be considered. We felt there was both consolidation and a little fluid. Here we have positive evidence of the T. B. adenitis, calcified cervical glands. No evidence of tuberculosis in either apex. The heart is perhaps enlarged a little but not much displaced to the right so the trachea is in the mid line."

DR. GORMLEY: "It is noted in the notes that the heart was slightly to the right of the mid line; that was a clinical observation."

Q.: "Did you pay any attention to the neurological findings?"

A.: "We paid all our attention to the neurological signs. We were trying to explain what caused the changing in the discs and her complete unconsciousness. It looked almost when she came in as if she were getting a respiratory paralysis."

Demonstration of Postmortem Material

DR. CLARKE: "On external examination there were numerous petechial hemorrhages over the skin and there was a scar of an old operation on the abdomen, and when we opened it we found the appendix and right tube and ovary were gone. In the left pleural cavity was 300 cc. of turbid fluid and in the right 250 cc. of fluid. Here is the left lung. The most interesting thing about it is that there is no pneumonia in it. It weighed 200 grams. The lower lobe of the lung is collapsed, while above it is fairly normal. The pericardial sac contained 200 cc. of slightly turbid fluid and the surfaces are covered with a thin layer of fibrin. A typical so called "bread and butter heart" of a fibrinous pericarditis. The heart is not very large. It weighs 325 grams. When we open the heart we find the pul-

monary valve is rather interesting in that there is a congenital anomaly. The valve has only two cusps instead of the usual three. Both of the coronary orifices are small but apparently normal. The other cusp of the heart is covered with vegetations and when we come to examine closely, we see this vegetation extending down on the endocardial surface and a probe passed in there enters a large abscess cavity and comes out on this side in the right auricle and there is a third communication through the surface of the left ventricle, so we have a large abscess of the heart wall, an abscess located in the interauricular septum and perforating into both ventricles and in the right auricle.

"Here is the spleen. It is quite large. It weighed 350 grams and in the spleen is a sort of wedge-shaped area of a different color slightly raised on the surface: an infarction of the spleen. Here are some pieces of kidney. You can see those little whitish areas in the cortex whose shape and color show a typical of infarcts."

Q.: "Is that recent?"

A.: "It is white so it must be three or four days old."

"In the liver we found one abscess on the under surface of the right lobe of the liver. We have here some sections from the brain. This is the right parietal region, and you can see it is hemorrhagic, blood stained, and before fixation these parts were much softer than the surrounding tissue. The microscope shows that all of these infarctions are septic infarcts. That is, they are infected. Staph. aureus was cultured from the heart's blood at post-mortem. The original diagnosis of staphylococcal septicemia is, of course, the correct one, but the interesting thing about it is that the primary lesion is apparently located in the heart with an unusual abscess in the heart wall and from that and from the vegetations of the valves emboli to various organs. The only lung pathology is secondary to cardiac failure. The liver also shows a little chronic passive congestion."

DR. GORMLEY: "I would like to call your attention to the X-ray and the heart which is not pulled toward the side where the atelectasis exists. Perhaps that fluid was coming rapidly at that time. It was taken on her way to the ward and at that time certainly she had no fluid in the right pleural cavity. Yet at that time the heart was pushed over and either she had a great deal more fluid in that cavity than we would diagnose, and it is noted in that pathological finding of the diagnosis that that heart was not pulled over to the side."

DR. BATCHELDER: "In the case of massive atelectasis the collapse is the primary thing and the heart is pulled over. In this instance it seems as though the collapse must have been secondary to the fluid and so there was no pull on the heart."

DR. BURGESS: "Isn't it worth saying a little more about that valve. Do not such congenital anomalies predispose to endocarditis? I should think it worth more than passing attention."

Q.: "How much fluid was in the right chest?"

A.: "250 cc."

Q.: "According to the postmortem findings, would this case be classified as subacute bacterial endocarditis?"

A.: "No. As far as the endocarditis is concerned, it would be acute ulcerative endocarditis, staphylococcic."

"Apparently all the abscesses here were infarcts. It is not exactly the picture you get with the so called pyemia. These are embolic abscesses."

SOCIETIES

PROVIDENCE MEDICAL ASSOCIATION

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Lucius C. Kingman, Monday evening, December 5, 1932, at 8:55 P. M. The records of the previous meeting were read and approved. The Standing Committee having approved their applications, the following gentlemen were elected to membership in the Association: Charles Bradley, David R. Brodsky, Morris L. Grover, Clarence J. Riley, Frederick R. Riley, and Walter C. Weigner. On motion of Dr. Brackett, the following resolution was adopted:

At the Annual Meeting in January, 1933, the Medical Milk Commission shall be appointed by the President, to consist of five members, one for five years, one for four years, one for three years, one for two years and one for one year; and thereafter one member shall be appointed by the President at each annual meeting, to serve for five years.

The first paper of the evening, "The Hemolytic Streptococcus," by Dr. Dennett L. Richardson and Dr. Harold E. Smiley, was presented by Dr. Richardson. He pointed out the great number of different types of infection caused by this organism, including scarlet fever, tonsillitis, laryngitis, pharyngitis, and erysipelas. Since 1929, at the Chapin Hospital, all patients on admission have had throat

cultures made to determine the presence of hemolytic streptococcus, and this paper is based on the results obtained. These cultures are made on standard blood agar plates, which reveal the presence of either hemolytic streptococcus or diphtheria bacillus. Dr. Richardson showed that, in the main, the incidence of carriers of hemolytic streptococcus is directly dependent upon the incidence of scarlet fever in the community. The diagnosis of scarlet fever by culture alone is not safe, but a positive culture is strong presumptive evidence. The absence of hemolytic streptococci in discharge cultures is not definite proof of inability to spread infection. The detection of these organisms in any throat culture should call for careful isolation of the patient to prevent the spread of serious infection.

The paper was discussed by Dr. A. M. Burgess, who pointed out that blood stream infections from this organism are not necessarily fatal, and do not always call for a grave prognosis; and by Dr. E. S. Brackett, who gave interesting data concerning infections by this organism in puerperal patients.

"Avertin Anesthesia in General Surgery" was the subject of the second communication presented by Dr. Anthony V. Migliaccio. He described the physical characters of trideromethanol, pointing out the reasons for extreme care in the preparation of the anesthetic mixture. He stressed the absence of trouble if the usual precautions are observed. The technique of the administration was described in detail. Dr. Migliaccio pointed out that respiratory excursions become shallower under this anesthetic, and that this can be offset by the administration of CO₂. At present, avertin is used only as a basal anesthetic, and no attempt is made to obtain complete anesthesia. This anesthetic is particularly useful in gynecological cases, operations about the mouth, and thyroid cases. The contraindications are advanced kidney disease, severe liver damage, obesity, ulcerations of the rectum, and debility. A series of seventy-five administrations was reported. These administrations included operations on the head and neck, thorax, abdomen, perineum and extremities. The paper was discussed by Dr. W. MacGilord, chief anesthetist of the Memorial Hospital of Worcester and instructor in anesthesia at the Harvard Dental School, and by Dr. A. H. Miller.

The rest of the meeting took the form of a surprise tribute to Dr. Charles H. Leonard, whose ninety-first December was to come December 29th.

Dr. Henry J. Hoyer showed a movie featuring Dr. Leonard in the Memorial Day parade. After this, Dr. John E. Donley gave a delightful short account of Dr. Leonard's career, mentioning his Civil War service, his presidency of the Medical Association in 1889-1891, and the tremendous amount of vaccination work done in his later years. Dr. Donley in a charming manner pictured the scholarly and humanitarian interests of Dr. Leonard, and the friendship and esteem of the Association, at whose meetings he is such a constant and interested attendant.

At 10:45 P. M. the meeting adjourned for a collation and Dr. Leonard cut a handsome birthday cake decorated with candles which formed the figures 91.

Attendance, 200. This probably is the largest meeting the Association has ever held.

Respectfully submitted,

WILFRED PICKLES, M.D.,
Secretary Pro Tem.

The annual meeting of the Providence Medical Association was called to order by the President, Dr. Lucius C. Kingman, Monday evening, January 2, 1933, at 9 P. M. The records of the previous meeting were read and approved. The annual reports of the Secretary, the Standing Committee, the Reading Room Committee, the Treasurer, and the Medical Milk Commission were read and accepted.

The paper of the evening was presented by Dr. Daniel Fiske Jones of Boston on the subject, "The Diagnosis and Treatment of Carcinoma of the Colon and Rectum." He deplored the lack of interest on the part of the general practitioner in this subject and suggested that any patient suffering any change in bowel habits or having any bleeding should be investigated for the presence of carcinoma in the colon. Bleeding is the most important symptom and should always call for study. Constipation is a late symptom, and the prevalent use of oil serves to mask this symptom very effectively for many months. This condition then passes into one of diarrhea or, as the patient will usually phrase it, frequent bowel movements. Pain is of importance in these cases, but patients rarely admit the presence of pain and it is not an outstanding symptom. Loss of weight is a late symptom and only comes when loss of appetite causes it.

Masses in the abdomen are frequently missed because of incomplete examination. Digital exami-

nation is of the greatest importance and should be done with the patient in the Sims position. Vaseline is a better lubricant than the lighter substances commonly used. Digital examination should always be made before proctoscopy is undertaken. Proctoscopy should be used to determine the source of bleeding, but this will not always show the growth. The proctoscope can be used as an instrument for feeling growths as well as for seeing them.

X-ray examination should not be undertaken until digital and proctoscopic examination have been used. Forty per cent of cancers of the rectum are missed, and twenty-five per cent of cancers of the colon are missed on the average X-ray examination. The greatest errors are made at the flexures and in the cecum. To complete the diagnosis a specimen should be removed. This not only confirms the diagnosis but tells us the degree of malignancy.

Radical operation in carcinoma of the rectum should be undertaken much more frequently than it is done at the present time. Colostomy should not be regarded with such fear as is common; patients can live in comfort and happiness with a colostomy, if they can be kept constipated and have a movement once daily with an enema.

Radium is of value in a small number of cases, particularly in those patients having lateral growths. It cannot be used in annular tumors. It also causes a great deal of pain and discomfort, and surgery must be considered preferable in the great majority of cases.

Dr. Jones completed his presentation with a series of slides showing 50 to 70 per cent of patients alive five years after operation.

The President's annual address was then delivered by Dr. Kingman, who urged the need of more work on the part of the members of the Association. More papers should be written and there should be brisk competition for the privilege of reading these at meetings of the society. Discussion should be freer and there should not be so great deference to authority. Case reports should be more frequent, as should be the presentation of specimens.

Dr. Kingman urged greater support of the Rhode Island Medical Society as the organized body of medical men in the state.

The election of officers was then proceeded with. On motion of Dr. Mowry the by-laws were suspended and the officers as nominated were elected by the casting of a single ballot by the Secretary.

In accordance with Article I, Section 6, of the by-laws, the Standing Committee made the following nominations for offices and committees for the year 1933:

For President—James W. Leech, M.D.

For Vice President—Charles F. Gormley, M.D.

For Secretary—Peter Pineo Chase, M.D.

For Treasurer—Charles F. Deacon, M.D.

For member of the Standing Committee for five years—Lucius C. Kingman, M.D.

For trustee of the Rhode Island Medical Library for one year—Henry J. Hoyer, M.D.

For Reading Room Committee—George S. Mathews, M.D., Elihu Wing, M.D., Guy W. Wells, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society—H. Libby, M.D., A. W. Mahoney, M.D., J. A. Gilbert, M.D., C. W. Skelton, M.D., T. Grzebien, M.D., F. W. Dimmitt, M.D., R. DiLeone, M.D., L. I. Kramer, M.D., W. A. Horan, M.D., P. C. Cook, M.D., J. J. Hoey, M.D., R. R. Baldridge, M.D., C. C. Dustin, M.D., E. A. Sharpe, M.D., J. G. Walsh, M.D., C. H. Woodmansee, M.D., R. H. Whitmarsh, M.D., V. J. Oddo, M.D., W. Hindle, M.D., P. P. Chase, M.D.

For Councillor for two years—Clinton S. Westcott, M.D.

The President appointed the following committees:

For Collation—Dr. A. V. Migliaccio and Dr. Charles J. Ashworth.

For Publicity—Dr. F. N. Brown, 3 years; Dr. C. F. Gormley, 2 years; and Dr. I. Gerber, 1 year.

Medical Milk Commission—Dr. H. P. B. Jordan, 5 years; Dr. H. G. Calder, 4 years; Dr. R. C. Bates, 3 years; Dr. A. R. Newsam, 2 years; Dr. W. P. Buffum (chairman), 1 year.

Public Relations—Dr. L. C. Kingman, 3 years; Dr. M. Adelman, 2 years; Dr. C. F. Gormley, 1 year.

The following sums were voted to the Medical Library: For appreciation of building privileges, \$450.00; for reading room, \$250.00; for binding periodicals, \$200.00. The annual dues were voted to be \$5.00.

Dr. James W. Leech was then escorted to the platform by Drs. Herman C. Pitts and A. A. Barrows.

The meeting adjourned at 10:30. Attendance, 155. Collation was served.

Respectfully submitted,

WILFRED PICKLES, M.D.,
Secretary Pro Tem.

HOSPITALS

ST. JOSEPH'S HOSPITAL STAFF ASSOCIATION

A meeting of the St. Joseph's Hospital Staff Association was held January 12, 1933, at 8:45 P. M. in the new auditorium on Peace Street.

Program follows: Discussion of the Thymus Gland by the Pediatric, X-ray and Pathological Departments, with report of cases.

Collation was served.

FRANK E. McEVoy, *President*;
EARL F. KELLY, *Secretary*.

NOTICE

The American Board of Obstetrics and Gynecology proposes to hold the first of a series of annual dinners for Diplomates of the Board and their friends on the first day of the Scientific Session of the American Medical Association meeting in Milwaukee, at which time the successful candidates from the examination of the day before will be introduced in person, one or more addresses will be made by officers of the Board and a Round Table Conference and general discussion of the activities of the Board will follow. Diplomates expecting to be in attendance at the Scientific Session of the American Medical Association are urged to make reservation for this subscription dinner as early as possible through the office of the Secretary of this Board. Further announcements will be made through the Journal of the American Medical Association and the American Journal of Obstetrics and Gynecology.

The next written examination and review of case histories will be held in cities throughout this country and Canada, where there are Diplomates who may be empowered to conduct the examination, on April 1, 1933.

The next general, clinical examination is to be held in Milwaukee on Tuesday, June 13, 1933, immediately preceding the annual session of the American Medical Association. Reduced railroad rates will apply.

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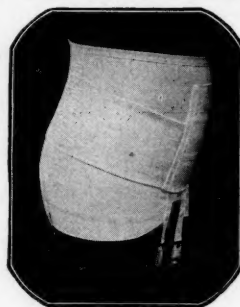
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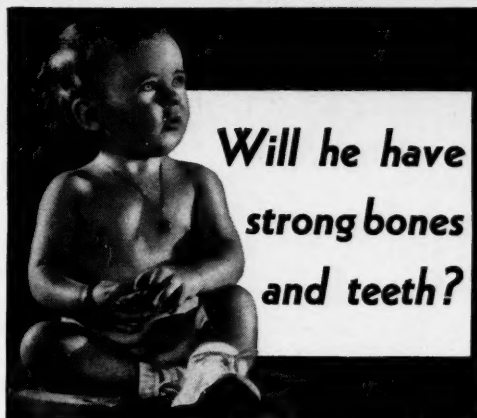


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